ANNEXURE V

F M C NETWORK UAE

P. O. BOX: 50430, DUBAI, Tel – 04 3871900, Fax – 04 3977842
Email – approval@fmchealthcare.ae Helpline Number: 600-565691

Medical Expenses Claim form

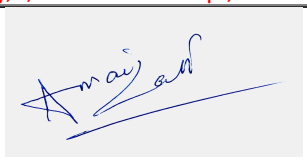
Date: 16-Mar-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1996-9189741-9
Card Holder's Name: EMMA KAREEM ALDRUBY Age: 28Y - 8M - 19D Sex: Female
Card Holder's Tel No: Mobile No: 050971871
Ins Card No: I038-010-121769884-01 Valid Upto: 22/3/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Syrian

Clinical Details: Temp37 B.P.107 Pulse. 74
Signs & Symptoms:
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow
Diagnosis: N21.9 - Calculus of lower urinary tract, unspecified, N76.0 - Acute vaginitis, Z87.440 - Personal history of urinary (tra infections, E86.0 - Dehydration, R03.1 - Nonspecific low blood-pressure reading

Management plan (Services inside the clinic including injections and investigations)

0102-152902-1001, LACTATED RINGERS INJECTION USP , Pharmacy,0005-136504-1021, SCOPINAL , Pharmacy,96360, HYDRATIC INFUSION INIT , Co.Pay,0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy,81015, MICROSCOPIC EXAM OF URINE , Lab,85 COMPLETE CBC AUTOMATED , Lab,96361, HYDRATE IV INFUSION ADD-ON , Co.Pay,9, Consultation Gp , General Consultation

Doctor's Name: DR Amaizah signature with seal:



Dr. Amaizah Isl
General Practitio
DHA: 98486553-(
CITICARE MEDICAL
DUBAI - U.A.E

Diagnostic Procedures referred outside:

I hereby authorize the physician, Hospital or pharmacy to file a claim for medical services on my behalf and I confirm that the a mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy c person who has provided medical services to me to furnish any and all information with regard to any medical history, medical medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 16-Mar-2025

Pharmaceuticals (to be filled by treating doctor only)